STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G449		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 10/31/2022	
	PROVIDER OR SUPPLIER NITY ALTERNATIVES-ADEPT	STREET A 7859 DI INDIAN			
(X4) ID PREFIX TAG E 0000	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	(X5) COMPLETION DATE	
E 0000	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.475. Survey Date: 10/31/22 Facility Number: 000963 Provider Number: 15G449 AIM Number: 100244740 At this Emergency Preparedness survey, Community Alternatives-Adept was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.475.	E 0000			
E 0037 Bldg	The facility has 6 certified beds. All 6 beds are certified for Medicaid. At the time of the survey, the census was 6. Quality Review completed on 10/31/22 The requirement at 42 CFR, Subpart 483.475 is NOT MET as evidenced by: 403.748(d)(1), 416.54(d)(1), 418.113(d)(1), 441.184(d)(1), 482.15(d)(1), 483.475(d)(1), 483.73(d)(1), 484.102(d)(1), 485.625(d)(1), 485.68(d)(1), 485.727(d)(1), 485.920(d)(1), 486.360(d)(1), 491.12(d)(1) EP Training Program \$403.748(d)(1), \$416.54(d)(1), \$418.113(d)(1), \$441.184(d)(1), \$460.84(d)(1), \$482.15(d)(1), \$483.73(d)(1), \$483.475(d)(1), \$484.102(d)(1), \$485.68(d)(1), \$485.625(d)(1), \$485.727(d) (1), \$485.920(d)(1), \$486.360(d)(1),		TITLE	(X6) DATE	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Bob Morris QIDP Manager 11/04/2022

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G449			UILDING	NSTRUCTION		SURVEY LETED /2022			
		PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD 7859 DELBROOK DR INDIANAPOLIS, IN 46260					
_	(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROI DEFICIENCY)	ON BE PRIATE	(X5) COMPLETION DATE	
		*[For RNCHIs at § Hospitals at §482. HHAs at §484.102 §485.727, OPOs at §491.12:] (1) Training prograll of the following (i) Initial training in policies and proceexisting staff, indivunder arrangement consistent with the (ii) Provide emergat least every 2 ye (iii) Maintain docupreparedness trai (iv) Demonstrate semergency proceed (v) If the emergen and procedures at [facility] must concupdated policies at The hospice must (i) Initial training in policies and proceexisting hospice existing hospice hospice hospi	n emergency preparedness edures to all new and viduals providing services nt, and volunteers, eir expected roles. gency preparedness training ears. Immentation of all emergency ning. staff knowledge of dures. In the staff knowledge of dures and procedures. §418.113(d):] (1) Training. It do all of the following: In emergency preparedness edures to all new and employees, and individuals is under arrangement, eir expected roles. It staff knowledge of dures. In gency preparedness training security of the staff knowledge of dures. In gency preparedness training security of the staff knowledge of dures.						

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Event ID:

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	1	ЛLDING		COMPL	
		15G449	B. Wl	ing		10/31	/2022
NAME OF F	PROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD		
COMMU	NITY ALTERNATIV	ES ADEDT			ELBROOK DR APOLIS, IN 46260		
COMMO	NIIT ALIEKNAIIV	ES-ADEF I		INDIAN	AFOLIS, IN 40200		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY (DATE
	and others.	ecessary to protect patients					
		mentation of all emergency					
	preparedness trail						
	(vi) If the emergency preparedness policies						
	and procedures are significantly updated, the						
	-	duct training on the					
	updated policies and						
	procedures.						
	-	l41.184(d):] (1) Training					
		TF must do all of the					
	following:	n emergency preparedness					
		edures to all new and					
		viduals providing services					
	-	nt, and volunteers,					
		eir expected roles.					
		ning, provide emergency					
	' '	ning every 2 years.					
	(iii) Demonstrate s	staff knowledge of					
	emergency proced						
		mentation of all emergency					
	preparedness train	•					
	` '	cy preparedness policies					
	•	re significantly updated, the					
		uct training on the updated					
	policies and proce	tuules.					
	*[For PACE at \$46	60.84(d):] (1) The PACE					
	,	do all of the following:					
	_	n emergency preparedness					
		edures to all new and					
	1 '	viduals providing on-site					
	services under arr	rangement, contractors,					
		olunteers, consistent with					
	their expected role						
	1 ` '	ency preparedness training					
	at least every 2 ye						
	(iii) Demonstrate s	staff knowledge of					

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Event ID:

RLF721

Facility ID: 000963

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUI	LDING	<u></u>	COMPL	ETED	
		15G449	B. WIN	IG		10/31/	/2022	
		1	 	STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF I	PROVIDER OR SUPPLIEF	8			ELBROOK DR			
СОММИ	NITY ALTERNATIV	ES-ADEPT	INDIANAPOLIS, IN 46260					
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	P	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
		dures, including informing						
		at to do, where to go, and						
		n case of an emergency.						
	(iv) Maintain documentation of all training.							
		ncy preparedness policies						
		re significantly updated, the						
		uct training on the updated						
	policies and procedures.							
	*[For LTC Facilities at §483.73(d):] (1)							
	Training Program. The LTC facility must do all							
	of the following:							
	(i) Initial training in emergency preparedness							
	policies and procedures to all new and							
	-	viduals providing services						
	under arrangemer							
	consistent with the							
		ency preparedness training						
	at least annually.							
	' '	mentation of all emergency						
	preparedness train	· ·						
	(iv) Demonstrate s	_						
	emergency proced	dures.						
	*[For CORFs at §4	485.68(d):](1) Training. The						
	CORF must do all	of the following:						
	(i) Provide initial tr	raining in emergency						
	preparedness poli	icies and procedures to all						
	new and existing	staff, individuals providing						
	services under arr	rangement, and volunteers,						
	consistent with the	eir expected roles.						
	(ii) Provide emerg	ency preparedness training						
	at least every 2 ye	ears.						
	(iii) Maintain docu	mentation of the training.						
	(iv) Demonstrate s	staff knowledge of						
	emergency proced	dures. All new personnel						
	must be oriented	and assigned specific						
		garding the CORF's						
		vithin 2 weeks of their first						
	workday. The training program must include							

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G449		A. BU	A. BUILDING B. WING			COMPLETED 10/31/2022		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 7859 DELBROOK DR INDIANAPOLIS, IN 46260					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		TE	(X5) COMPLETION DATE	
IAU	instruction in the losystems and signal equipment. (v) If the emerge and procedures and disaster author existing staff, individuals and procedures to all remergency prepared procedures to all remergency prepared procedures and procedures to all remergency prepared procedures and p	cocation and use of alarm als and firefighting ncy preparedness policies re significantly updated, the act training on the updated adures. 85.625(d):] (1) Training remarks and remarks		TAU			DATE	
		the training. The CMHC staff knowledge of						

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Event ID:

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G449		(X2) MULTIPLE (A. BUILDING B. WING			
	PROVIDER OR SUPPLIER		7859	FADDRESS, CITY, STATE, ZIP COD DELBROOK DR NAPOLIS, IN 46260	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
IAU	emergency proced CMHC must provipreparedness train Based on record revision failed to ensure staff to emergency preparedness. The IC following: (i) Provipreparedness policicand existing staff, in under arrangement, with their expected preparedness trainin (iii) Maintain docur Demonstrate staff k procedures in accor (1). This deficient poccupants. Findings include: Based on review of Preparedness Manu 05/13/22 and "Emergence of 11:25 and occupants of the procedure of the proparedness plan with the proparedness plan with the procedure of the preparedness plan with the procedure of the preparedness plan with the procedure of the preparedness policical documentation with period was not available.	dures. Thereafter, the de emergency ning at least every 2 years. riew and interview, the facility of received training in regards redness policies and F/IID facility must do all of the de initial training in emergency es and procedures to all new individuals providing services and volunteers, consistent roles; (ii) Provide emergency ag at least every two years; mentation of the training; (iv) mowledge of emergency dance with 42 CFR 483.475(d) practice could affect all "Emergency/Disaster all" documentation dated faintenance Aide during record fam. to 12:15 p.m. on 10/31/22, aff training on the emergency within the most recent two year lable for review. Based on the of record review, the agreed emergency es and procedure staff training in the most recent two year lable for review.	E 0037	CORRECTION: The facility must have a train program on place with (i) Initial training in emergency preparedness policies and procedures to all new and existaff, individuals providing on services under arrangement, volunteers, consistent with the expected roles. (ii) Provide emergency preparedness training Demonstrate staff knowledge emergency procedures. Specifically, the facility will prain emergency preparedness training program that includes following. Initial training in emergency preparedness training staff, individuals provide emergency preparedness training demonstrate staff knowledge emergency preparedness training demonstrate staff knowledge emergency procedures. Facil Specific Emergency Prepared Training has been added to rhire On-the-Job Training curriculum and Area Supervisand the QIDP will be respons for providing annual retraining well as training when the plant well as training well as training when the plant well as training well as training when the plant well as training well as traini	ing ial 11/30/2022 ing ial isting posite and reir ining in (iv) e of rovide is the licies in ining in (i); and of lity dness new isors sible g as

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Event ID:

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Facility ID: 000963

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AND PLAN OF CORRECTION IDE		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G449	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 10/31/2022		
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD 7859 DELBROOK DR INDIANAPOLIS, IN 46260				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	(X5) COMPLETION DATE			
				updated. The QIDP Manager will work withe Human Resources Team a facility management to maintal reproducible system to provide training documentation to regulatory agencies. PREVENTION: Members of the Operations Team (comprised of the Operations Managers, Program Managers Nurse Manager, Executive Director, Quality Assurance Manager, Quality Assurance Coordinators and QIDP Management will incorporate reviews of the facility's emergency preparedre program into scheduled twice monthly audits to assure all required components are present Additionally, the agency Safety Committee will review and review the plan as needed but no less than annually. RESPONSIBLE PARTIES: QII Area Supervisor, Direct Support Lead, Safety Committee, Hum Resources Department, Operations Team, Regional Director	vith and in a e eam s, ger) ness ent. y ise s DP, ort		
E 0039 Bldg	441.184(d)(2), 484 483.73(d)(2), 484 485.68(d)(2), 485 486.360(d)(2), 49 EP Testing Requi §416.54(d)(2), §4	6.54(d)(2), 418.113(d)(2), 2.15(d)(2), 483.475(d)(2), .102(d)(2), 485.625(d)(2), .727(d)(2), 485.920(d)(2), 1.12(d)(2), 494.62(d)(2) rements 18.113(d)(2), §441.184(d)(2), 82.15(d)(2), §483.73(d)(2),					

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§483.475(d)(2), §484.102(d)(2), §485.68(d)(2),

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CENTERS FOR MEDICARE & MEDICAID SERVICES						OM	IB NO. 0938-039
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILD	ING		COMPI	LETED
		15G449	B. WING			10/31	/2022
			Lar	DEET 4	DDDEGG CHTU CT LTE TID COD		
NAME OF	PROVIDER OR SUPPLIEF	3			ADDRESS, CITY, STATE, ZIP COD		
0014141		VEC ADEDT			ELBROOK DR		
COMMO	NITY ALTERNATIV	ES-ADEPT	IIV	IDIAN	APOLIS, IN 46260		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	II)	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PRE	FIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATF	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TA	ΔG	DEFICIENCY)		DATE
	§485.625(d)(2), §-	485.727(d)(2), §485.920(d)					
	(2), §491.12(d)(2)	, §494.62(d)(2).					
	.,,	- , , , ,					
	*[For ASCs at §41	16.54, CORFs at §485.68,					
	_	ons" under §485.727,					
	_	20, RHCs/FQHCs at					
	§491.12, and ESF	RD Facilities at §494.62]:					
	(2) Testing. The [f	facility] must conduct					
	exercises to test t	he emergency plan					
	annually. The [facility] must do all of the following:						
	(i) Participate in a	full-scale exercise that is					
		l every 2 years; or					
		nunity-based exercise is					
	not accessible, co	onduct a facility-based					
	functional exercise	e every 2 years; or					
	(B) If the [fac	ility] experiences an actual					
	natural or man-ma	ade emergency that requires					
	activation of the e	mergency plan, the [facility]					
	is exempt from en	gaging in its next required					
	community-based	or individual, facility-based					
	functional exercis	e following the onset of the					
	actual event.						
	(ii) Conduct an ad	lditional exercise at least					
	every 2 years, op	posite the year the full-scale					
		cise under paragraph (d)(2)					
	(i) of this section i	s conducted, that may					
	include, but is not	limited to the following:					
	(A) A second full-	scale exercise that is					
	community-based	l or individual, facility-based					
	functional exercis	e; or					
	(B) A mock disast	er drill; or					
		ercise or workshop that is					
		and includes a group					
	discussion using a						
	_	emergency scenario, and a					

set of problem statements, directed

messages, or prepared questions designed

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING		COMPL	ETED
		15G449	B. W	ING		10/31/	/2022
			_	STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIEF	{		7859 DI	ELBROOK DR		
COMMU	NITY ALTERNATIV	ES-ADEPT		INDIAN.	APOLIS, IN 46260		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	to challenge an er						
		acility's] response to and					
		ntation of all drills, tabletop					
		nergency events, and revise					
	the [facility's] eme	rgency plan, as needed.					
	*[For Hospices at	418 113(d)·1					
		spices that provide care in					
		e. The hospice must					
		to test the emergency					
		ally. The hospice must do					
	the following:	any. The heapide made de					
	_	a full-scale exercise that is					
	community based every 2 years; or						
		nunity based exercise is not					
	' '	ct an individual facility					
		exercise every 2 years; or					
		experiences a natural or					
		ency that requires activation					
	_	plan, the hospital is					
		aging in its next required full					
		based exercise or individual					
		tional exercise following the					
	onset of the emer	_					
		dditional exercise every 2					
	years, opposite th	e year the full-scale or					
	functional exercise	e under paragraph (d)(2)(i)					
	of this section is c	onducted, that may					
	include, but is not	limited to the following:					
	(A) A second full-	scale exercise that is					
	community-based	or a facility based					
	functional exercise	e; or					
	(B) A mock disas	ter drill; or					
	(C) A tabletop ex	ercise or workshop that is					
	led by a facilitator	and includes a group					
	discussion using a	a narrated,					
	clinically-relevant	emergency scenario, and a					
	set of problem sta						
	messages, or pre	pared questions designed					
	to challenge an emergency plan.						

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 15G449	A. BU B. WI	JILDING ING		10/31/	
		130449	D. WI			10/31/	2022
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
COMMUI	NITY ALTERNATIV	ES-ADEPT			ELBROOK DR APOLIS, IN 46260		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	L PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		TE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	care directly. The exercises to test the per year. The hose (i) Participate in a that is community. (A) When a commaccessible, conduct facility-based functional exercise emergency exempt from engate full-scale community functional exercise emergency event. (ii) Conduct an activate may include, following: (A) A second full-community-based functional exercise functional exercise (B) A mock disast (C) A tabletop extracilitator that including a narrated, emergency scena statements, direct questions designed emergency plan. (iii) Analyze the homaintain documer exercises, and emergency semester exercises and emergency emergency emergency emergency emergency emergency emergency plan.	nunity-based exercise is not lect an annual individual extional exercise; or experiences a natural or ency that requires activation plan, the hospice is aging in its next required nity based or facility-based e following the onset of the exercise but is not limited to the excale exercise that is or a facility based e; or ter drill; or ercise or workshop led by a udes a group discussion clinically-relevant rio, and a set of problem end messages, or prepared ed to challenge an exercise to and natation of all drills, tabletop nergency events and revise ergency plan, as needed.					
	§482.15(d), CAHs	l41.184(d), Hospitals at s at §485.625(d):] PRTF, Hospital, CAH] must					

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	PARTMENT OF HEALTH AND HUMAN SERVICES NTERS FOR MEDICARE & MEDICAID SERVICES							
STATEMEN	VT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	A. BUILI		NSTRUCTION	(X3) DATE COMPL	ETED	
NAME OF I	PROVIDER OR SUPPLIER	15G449	B. WING	TREET A	ADDRESS, CITY, STATE, ZIP COD	10/31/	72022	
	NITY ALTERNATIV				ELBROOK DR APOLIS, IN 46260			
	T						(7/5)	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		D EFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION	
TAG	•	R LSC IDENTIFYING INFORMATION		AG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE	
1710		s to test the emergency	1	710			DATE	
		ar. The [PRTF, Hospital,						
	CAH] must do the							
	_	an annual full-scale exercise						
	that is community							
	(A) When a comm	nunity-based exercise is not						
	accessible, condu	ıct an annual individual,						
	facility-based fund	ctional exercise; or						
		Hospital, CAH] experiences						
		or man-made emergency						
	-	ation of the emergency						
		is exempt from engaging in						
	•	ull-scale community based						
		ty-based functional exercise						
	_	et of the emergency event.						
		an [additional] annual						
	limited to the follo	at may include, but is not						
		scale exercise that is						
	community-based							
	-	ctional exercise; or						
	-	ock disaster drill; or						
	, ,	exercise or workshop that						
	. ,	or and includes a group						
	discussion, using	a narrated,						
	clinically-relevant	emergency scenario, and a						
	set of problem sta	tements, directed						
		pared questions designed						
	to challenge an er							
	, ,	he [facility's] response to						
		umentation of all drills,						
	•	s, and emergency events						
	_	cility's] emergency plan, as						
	needed.							
	*[For PACE at §46	80 84/d):1						
	-	PACE organization must						

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conduct exercises to test the emergency plan at least annually. The PACE organization must do the following:

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		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING		COMPL	
		15G449	B. W	ING		10/31	/2022
NAME OF I	PROVIDER OR SUPPLIER)	•	STREET A	ADDRESS, CITY, STATE, ZIP COD		
					ELBROOK DR		
COMMU	NITY ALTERNATIV	ES-ADEPT		INDIAN	APOLIS, IN 46260		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE
	that is community	an annual full-scale exercise					
	(A) When a community-based exercise is not accessible, conduct an annual individual,						
		ctional exercise; or					
		xperiences an actual natural					
	' '	ergency that requires					
		mergency plan, the PACE					
		gaging in its next required					
	•	nity based or individual,					
		tional exercise following the					
	onset of the emer						
		n additional exercise every					
	2 years opposite the year the full-scale or						
	functional exercise	e under paragraph (d)(2)(i)					
	of this section is c	onducted that may include,					
	but is not limited to	o the following:					
	(A) A second full-	scale exercise that is					
	community-based	or individual, a facility					
	based functional e	exercise; or					
	(B) A mock disas	ter drill; or					
	(C) A tabletop ex	ercise or workshop that is					
		and includes a group					
	discussion, using	a narrated,					
	· ·	emergency scenario, and a					
	set of problem sta						
		pared questions designed					
	to challenge an er						
		PACE's response to and					
		ntation of all drills, tabletop					
		nergency events and revise					
	the PACE's emero	gency plan, as needed.					
	*[For LTC Facilitie	es at §483.73(d):]					
	l -	ity] must conduct exercises					
		ency plan at least twice per					
		announced staff drills using					
		ocedures. The [LTC facility,					
	ICF/IID] must do t	=					
	<u> </u>	on annual full-scale exercise					

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G449	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 10/31/2022
	PROVIDER OR SUPPLIEF		7859 D	ADDRESS, CITY, STATE, ZIP COE ELBROOK DR IAPOLIS, IN 46260	,
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	LD BE COMPLETION
	accessible, condu- facility-based function (B) If the [LTC factor actual natural or requires activation LTC facility is exe- required a full-sca- individual, facility- following the onse- (ii) Conduct an actual may include, following: (A) A second full- community-based based functional extension and facilitator discussion, using clinically-relevant set of problem star messages, or pre- to challenge an er- (iii) Analyze the [I response to and response to an actual drills, tabletop events, and revise emergency plan, and the response to the response to the response to the response to an actual drills, tabletop events, and revise emergency plan, and the response to the response to a the response to the response to a the resp	nunity-based exercise is not ct an annual individual, stional exercise. ility] facility experiences an man-made emergency that in of the emergency plan, the mpt from engaging its next le community-based or based functional exercise st of the emergency event. In of the emergency event. In of the emergency event. In or an individual exercise but is not limited to the exercise; or ter drill; or exercise or workshop that is includes a group an anarated, emergency scenario, and a tements, directed pared questions designed emergency plan. LTC facility] facility's maintain documentation of exercises, and emergency exercises. In annual full-scale exercise in annual full-scale exercise			

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		IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G449		ILDING	NSTRUCTION	(X3) DATE COMPI 10/31	
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT			STREET ADDRESS, CITY, STATE, ZIP COD 7859 DELBROOK DR INDIANAPOLIS, IN 46260					
	X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	1	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	LD BE	(X5) COMPLETION DATE
		facility-based fund (B) If the ICF/IID of natural or man-materization of the exist exempt from erfull-scale community-based fund onset of the emer (ii) Conduct an additional that may include, following: (A) A second full-community-based facility-based fund (B) A mock disast (C) A tabletop existed by a facilitation discussion, using clinically-relevant set of problem stated messages, or preto challenge an erfuility Analyze the IC maintain documer exercises, and enthe ICF/IID's eme *[For HHAs at §48 (d)(2) Testing. The exercises to test the least annually. The following: (i) Participate in a community-based (A) When a construction is not accessible, individual, facility-every 2 years; or. (B) If the HH	extronal exercise; or. experiences an actual ade emergency that requires mergency plan, the ICF/IID agaging in its next required nity-based or individual, ctional exercise following the agency event. ditional annual exercise but is not limited to the scale exercise that is for an individual, ctional exercise; or er drill; or ercise or workshop that is and includes a group a narrated, emergency scenario, and a attements, directed pared questions designed mergency plan. CF/IID's response to and antation of all drills, tabletop mergency events, and revise regency plan, as needed. 34.102] e HHA must conduct the emergency plan at e HHA must do the					

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	ENT OF DEFICIENCIES N OF CORRECTION	IDENTIFICATION NUMBER 15G449	A. BUILDING B. WING			LETED /2022		
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT			STREET ADDRESS, CITY, STATE, ZIP COD 7859 DELBROOK DR INDIANAPOLIS, IN 46260					
(X4) ID PREFIX TAG	(EACH DEFICIEN	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAL TAG DEFICIENCY)		(X5) COMPLETION DATE		
	exempt from engate full-scale community based functional exercise of this section is conclude, but is not (A) A second community-based facility-based functional exercise facility-based facility-based functional exercise functional exercise functional exercise functional exercises functional exercises, and entitle exercises functional exercises functional exercises functional exercises functional exercise fun	ditional exercise every 2 e year the full-scale or e under paragraph (d)(2)(i) onducted, that may limited to the following: full-scale exercise that is or an individual, stional exercise; or isaster drill; or o exercise or workshop that or and includes a group a narrated, emergency scenario, and a tements, directed pared questions designed mergency plan. HA's response to and intation of all drills, tabletop inergency events, and revise ency plan, as needed. 36.360] e OPO must conduct the emergency plan. The						

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CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039									
Ì		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G449	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 10/31/2022				
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT		7859 D	ADDRESS, CITY, STATE, ZIP COD DELBROOK DR NAPOLIS, IN 46260						
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL . LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	(X5) COMPLETION DATE				
	OPO is exempt from required testing exempt from required testing exempt from required testing exempt from the exercises, and emit the [RNHCl's and needed. *[RNCHIs at §403 (d)(2) Testing. The exercises to test the sexempt from the exercises and emit the exercises, and emit the exercises, and emit the exercises, and emit the RNHCl's emer exercises, and emit the RNHCl's emer exercises, and emit the exercises, and emit the exercises, and emit the exercises for the exercise of the exerc	mengaging in its next dercise following the onset event. PO's response to and datation of all tabletop dergency events, and revise OPO's] emergency plan, as 3.748]: RNHCI must conduct the emergency plan. The defollowing: Per-based, tabletop exercise as and tabletop exercise is a ded by a facilitator, using a derelevant emergency plan. WHCI's response to and datation of all tabletop dergency events, and revise gency plan, as needed. WHCI's response to and datation of all tabletop dergency events, and revise gency plan, as needed. WHCI's response to test the data annual basis using the gency plan and interview, the facility deast two exercises to test the data annual basis using the gency (i) Participate in an annual data is community-based; or dity-based exercise is not an annual individual,	E 0039	CORRECTION: The [facility] must conduct exercises to test the emerger plan at least annually. Specifithe agency's Quality Assuran Department has submitted a formal request to the Indianay Metropolitan Police Department/Department of Homeland Security Communi Emergency Response Team (CERT) to conduct an initial "Italk" disaster exercise, with bi-annual exercises thereafter Additionally, the ResCare Qui	11/30/2022 acy cally, ce polis ty table r.				

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year following the onset of the actual event.

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Assurance Department has

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G449	ì	UILDING	ONSTRUCTION	(X3) DATE COMPL 10/31/	ETED
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT			STREET ADDRESS, CITY, STATE, ZIP COD 7859 DELBROOK DR INDIANAPOLIS, IN 46260				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION		TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
		litional exercise that may			requested assistance from the	<u> </u>	
		imited to the following:			IMPD District Commander to	•	
	a. A second full-sca				coordinate with CERT to facili	tate	
		or an individual, facility-based			this process. ResCare Facility		
	functional exercise.	-			supervisors, the QIDP and		
	b. A mock disaster				administrative level managem	ent	
		ise or workshop that is led by a			(Operations Managers, Progra		
	_	ides a group discussion led by			Managers, Quality Assurance		
		a narrated, clinically-relevant			Manager, QIDP Manager, Qu		
	_	o, and a set of problem			Assurance Coordinators, Nurs	•	
		d messages, or prepared			Manager and Assistant Nurse		
	·	to challenge an emergency			Manager) will participate in the		
	plan.				exercises to assure facility	J	
	(iii) Analyze the ICF/IID facility's response to and				emergency preparedness		
		ation of all drills, tabletop			protocols are consistent with		
		rgency events, and revise the			community emergency		
		mergency plan, as needed in			management practices.		
		2 CFR 483.475(d)(2). This	The facility will develop				
		ould affect all occupants.			documentation of the activation	n of	
	1	1			the Emergency Preparedness		
	Findings include:				Plan during the COVID-19		
					epidemic, by 11/17/22 using t	he	
	Based on review of	"Emergency/Disaster			state of emergency as a platfo		
		ual" documentation dated			At the time of this exercise, a		
	_	ergency, Disaster, Evacuation			"table talk exercise will be		
	Plans & Responses	" documentation dated			scheduled with local emergen	су	
	_	Maintenance Aide during record			management officials within 6	-	
	review from 11:25	a.m. to 12:15 p.m. on 10/31/22,			months of the full-scale event		
	documentation of a	community based disaster drill			The QIDP Manager will collab	orate	
	within the most rec	ent twelve month period was		with other residential p			
	not available for re-	view. Based on interview at the			determine a functional approa	ch to	
	time of record revie	ew, the Maintenance Aide			correct this deficient practice.		
	agreed the facility i	s currently experiencing an			PREVENTION:		
	actual natural emer	gency due to Covid-19 and			Members of the Operations T	eam	
	Covid-19 policy an	d procedures currently in effect			(comprised of the Executive		
	_	re stated in the emergency			Director, Operations Manager	s,	
		nentation but agreed the			Program Managers, Area		
	facility has not con-	ducted a second community			Supervisors, Quality Assurance	ce	
	based disaster drill	or conducted a tabletop			Manager, QIDP Manager, QII	OP,	
	exercise within the	most recent twelve month			Quality Assurance Coordinate	ors,	

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G449	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 10/31/2022
	PROVIDER OR SUPPLIER		7859 D	ADDRESS, CITY, STATE, ZIP COD ELBROOK DR JAPOLIS, IN 46260	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	DATE COMPLETION DATE
	time of the survey.	not available for review at the		Nurse Manager and Assis Nurse Manager) will incorreviews of the facility's empreparedness program intscheduled twice monthly assure all required composincluding but not limited to bi-annual community-based disaster exercises, are preadditionally, the agency SCommittee will review and the plan as needed but not than annually. RESPONSIBLE PARTIES Area Supervisor, Direct Schead, Direct Support Staff Operations Team, Region Director	porate nergency to audits to onents, o ed esent. safety d revise o less s: QIDP, upport f,
K 0000					
Bldg. 01	conducted by the In accordance with 42 Survey Date: 10/31 Facility Number: 0 Provider Number: 100/2 At this Life Safety 0 Alternatives - Adep with Requirements 42 CFR Subpart 48/2 and the 2012 Editio Protection Association	722 00963 15G449 244740 Code survey, Community t was found not in compliance for Participation in Medicaid, 3.470(j), Life Safety from Fire n of the National Fire ion (NFPA) 101, Life Safety er 33, Existing Residential	K 0000		

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ENTERS FOI	R MEDICARE & MEDIC	AID SERVICES			OMB NO. 0938-039
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G449	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 10/31/2022
	PROVIDER OR SUPPLIER		7859 D	ADDRESS, CITY, STATE, ZIP COD DELBROOK DR NAPOLIS, IN 46260	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
K S100 Bldg. 01	sprinklered. The fa with smoke detection areas. The facility the attic. The facility the attic. The facility a census of 6 at the Calculation of the F (E-Score) using NF Approaches to Life facility Prompt with Quality Review consumption of the F (E-Score) using NF Approaches to Life facility Prompt with Quality Review consumption of the F (E-Score) using NF Approaches to Life facility Prompt with Quality Review consumption of the F at 101 General Requirem General Requirem 2012 EXISTING List in the REMAF Section 33.1 or 33 that are not address K-tags, but are dealong with the app NFPA standard cing on Form CMS-25 Based on observation failed to ensure 1 of the teature of the provisions of Chapt Section 4.6.12.4 reconstruction of the feature requirement of the feature o	Evacuation Difficulty Score PA 101A, Alternative Safety, Chapter 6, rated the n an E-Score of 0.2. Impleted on 10/31/22 Innents - Other RKS section any LSC B.2 General Requirements ssed by the provided ficient. This information, blicable Life Safety Code or tation, should be included for. In and interview, the facility for 1 smoke barrier doors which lift close or automatic close with ectivation would resist the LSC Section 33.1.1.3 states the left 4, General, shall apply. LSC quires any device, equipment, larrangement, level of stive construction, or any	K S100	CORRECTION: The facility will ensure that portable fire extinguishers loc in the facility was inspected at least monthly and the inspective were documented including the date and initials of the person performing the inspection. Specifically, the facility will repetite smoke barrier door to assemble it closes it latches to the door frame to resist the passes of smoke.	t ions he pair ure

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practice could affect all clients, staff and visitors.

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PREVENTION:

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AND PLAN OF CORRECTION IDENTIFIC		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G449	(X2) MUL' A. BUIL B. WINC	DING	nstruction <u>01</u>	(X3) DATE COMPL 10/31/	ETED
	PROVIDER OR SUPPLIER			7859 DE	DDRESS, CITY, STATE, ZIP COD ELBROOK DR APOLIS, IN 46260	•	
(X4) ID PREFIX				ID EFIX	PROVIDER'S PLAN OF CORRECTION		(X5) COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	-	ΓAG	DEFICIENCY)	NIE	DATE
Findings include:				The Residential Manager or designee will incorporate mon fire extinguisher checks into the	•		
	Aide during a tour o	ons with the Maintenance of the facility from 12:15 p.m. to			facility's monthly Home Environment Safety Inspection		
	the dining room, wh	/22, the smoke barrier door in nich was held open with a wall nolding device set to release			Additionally, members of the Operations Team, comprised the Program Managers,	of	
	with fire alarm syste	em activation, failed to fully			Operations Manager, Nurse		
		into the door frame when ple times and would not resist			Manager, Registered Nurse, Executive Director, Quality		
		te. The face of the door kept ne when tested to close.			Assurance Manager, QIDP		
	Based on interview				Manager and Quality Assurant Coordinators will incorporate		
		aintenance Aide agreed the			checks smoke barrier doors in		
		would not resist the passage			scheduled monthly observation		
		ed to close and latch into the			the facility, to assure they fund		
	door frame.	to close the laten into the			properly.	Juon	
	door name.				RESPONSIBLE PARTIES: QI	DP	
	This finding was re	viewed with the Maintenance			Residential Manager,	DI ,	
	Aide during the exit				Environmental Services Team	1	
	That during the exit conference.				Operations Team	••	
K S712	NFPA 101 Fire Drills						
Bldg. 01	Fire Drills						
		t hold evacuation drills at					
		each shift of personnel and					
	under varied cond						
		ll personnel on all shifts are					
	trained to perform	-					
The state of the s		ll personnel on all shifts are					
	familiar with the us	<u>-</u>					
	emergency and di	saster plans and					
	procedures.						
	2. The facility mus						
		uate clients during at least					
	one drill each year						
		provisions for the					
	evacuation of clier	nts with physical	1				

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION X		(X3) DATE	X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>01</u> C			COMPL	ETED
		15G449	B. W	B. WING		10/31/	2022
STREET ADDRESS, CITY, STATE, ZIP COD			ADDRESS CITY STATE ZID COD				
NAME OF I	PROVIDER OR SUPPLIEF	₹			ELBROOK DR		
COMMU	NITY ALTERNATIV	ES ADEDT			APOLIS, IN 46260		
COMMO	NIII ALIENNAIIV	ES-ADEF I		INDIAN	AFOLIS, IN 40200		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	disabilities;						
	c. File a report a	and evaluation on each drill;					
	d. Investigate al	l problems with evacuation					
	drills, including ac	cidents and take corrective					
	action; and						
	e. During fire dri	ills, clients may be					
	evacuated to a sa	fe area in facilities certified					
	under the Health	Care Occupancies Chapter					
	of the Life Safety	Code.					
	3. Facilities must i	meet the requirements of					
	paragraphs (i) (1)	and (2) of this section for					
	any live-in and rel	ief staff that they utilize.					
	42 CFR 483.470(i						
		view and interview, the facility	K S	712	CORRECTION:		11/30/2022
		the time of day first and			The facility must hold evacuati	ion	
		lls were conducted for two of			drills at least quarterly for each	7	
	_	the most recent twelve month			shift of personnel and under va	aried	
	-	ent practice affects all clients,			conditions. Specifically, the fac	cility	
	staff and visitors.				will conduct additional evacua	tion	
					drills on each shift during the		
	Findings include:				current quarter.		
					PREVENTION:		
		"Emergency Evacuation Drill:			Professional staff will be retrai		
		n for the most recent twelve			regarding the need to conduct		
	_	the Maintenance Aide during			evacuation drills at varied time		
		11:25 a.m. to 12:15 p.m. on			each shift for all staff each qua		
		ving fire drills did not record the			Training will also focus on prop	per	
	time of day the drill				completion of evacuation drill		
		g shift 3:00 p.m. to 11:00 p.m."			forms and assessment of		
		ng shift 3:00 p.m. to 11:00 p.m."			individual drill compliance. The	9	
		ght 12 a.m. to 4:00 a.m."			Operations (comprised of the		
		ght 12 a.m. to 4:00 a.m."			Executive Director, Operations		
		ght 12 a.m. to 4:00 a.m."			Managers, Program Managers	5,	
		g shift 3:00 p.m. to 11:00 p.m."			Area Supervisors, Quality		
	_	ift 5:00 a.m. to 3:00 p.m."			Assurance Manager, QIDP		
		ng shift 3:00 p.m. to 11:00 p.m."			Manager, QIDP, Quality		
		g shift 3:00 p.m. to 11:00 p.m."			Assurance Coordinators, Nurs	е	
		hift 12 a.m. to 4:00 a.m."			Manager and Assistant Nurse	11	
	-	ift 5:00 a.m. to 3:00 p.m."			Manager) will review and track		
	1. 05/04/22 "evening	g shift 3:00 p.m. to 11:00 p.m."	1		facility evacuation drill reports	and	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G449	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE COMPL 10/31/	ETED
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT			7859 D	ADDRESS, CITY, STATE, ZIP COD ELBROOK DR IAPOLIS, IN 46260		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	REGULATORY OR LSC IDENTIFYING INFORMATION m. 05/09/22 "evening shift 3:00 p.m. to 11:00 p.m." n. 05/19/22 "day shift 5:00 a.m. to 3:00 p.m." o. 05/25/22 "overnight 12 a.m. to 4:00 a.m." p. 06/08/22 "evening shift 3:00 p.m. to 11:00 p.m." q. 06/14/22 "day shift 5:00 a.m. to 3:00 p.m." r. 06/20/22 "overnight 12 a.m. to 4:00 a.m." s. 06/29/22 "overnight 12 a.m. to 4:00 a.m." s. 06/29/22 "overnight 12 a.m. to 4:00 a.m." Based on interview at the time of record review, the Maintenance Aide contacted the Area Manager by telephone at 11:55 a.m. on 10/31/21 who stated the facility operates two shifts per day from 8:00 a.m. to 8:00 p.m., the shift times were incorrectly documented and agreed the aforementioned fire drill documentation did not include the time of day the fire drill was conducted. This finding was reviewed with the Maintenance			follow up with professional stare needed to assure drills occur is scheduled and follow up with agency Safety Committee accordingly. Responsible Parties: Environmental Services Team Area Supervisor, Residential Manager, Direct Support Staff QIDP, Operations Team	as the	

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